East West Naturopathic Clinic
Dr. Michelle K. Jackson, ND, PC
TIN #46-0501145 NPI #1821156142
61535 S. HWY 97 Ste-5-404 Bend, OR 97702
Phone # 541-385-0775
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Informed Consent For Naturopathic Treatment

I hereby authorize and direct Dr. Jackson, who is a naturopathic physician licensed in the State of Oregon to do the following:
1) To consult with me about my health concerns.
2) To run laboratory tests that we discuss and agree on.
3) To treat me with naturopathic medicine and/or conventional medicine, as my health condition requires, and as we discuss and agree on over time case-by-case basis.
I understand that there may be risks and consequences to my medical treatment, and that the practice of medicine involves many variables, some of which would be impossible to account for in every situation. I understand that it is impossible to guarantee the outcome of any medical treatment, and I have been given no guarantee as to the results that may be obtained.

I further understand that Dr. Jackson honors the following Patient Bill of Rights, as adapted from the American Association of Physicians and Surgeons. The following list of my rights includes but not limited to the rights below:
1. I have the right to seek consultation with any physician(s)of my choice, or refuse the same.
2. I have the right to medical treatment from my physician(s) on mutually agreeable terms.
3. I have the right to be treated confidentially, with access to my records limited to those involved in my care or designated by me.
4. I have the right to use my own resources to purchase the care of my choice
5. I have the right to refuse medical treatment,even if it is recommended by my physician or any other physician, hospital or clinic.
6. I have the right to be informed about my medical condition, and the risks and benefits of treatment and appropriate alternatives.
7. I have the right to refuse third-party interference in my care.

Patient Participation: In order to provide you with the best recommendations and evaluate contraindications to care, it is critical you provide us with complete and accurate information about your medical history, symptoms, medications and changes in condition or symptoms. In some instances, it is important we coordinate your care with your other providers, and/or refer you to other specialists. **Do not wait to be seen by our office or leave messages regarding urgent medical conditions. If you are experiencing an emergency, it is important that you go to a hospital or call 911**. Please tell us as soon as possible if you presented to urgent care or the emergency room.

Questions: Please list below any specific questions you have about this information or the treatment proposed. If none, please write "none":

Patient Questions:

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DO NOT SIGN BELOW UNTIL YOU HAVE MET WITH THE DOCTOR

I hereby acknowledge that I have provided complete and accurate information regarding my health history, medication and symptoms and will notify my doctor if there are any changes to same. I have discussed with the doctor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I understand there is no guarantee or warranty for a specific cure or result. I hereby give my full consent to treatment.

My signature here means I have read this information and understand it. The consent to treat is valid until revoked in writing.

Print Patient Name:____**DOB:**______________
Patient Signature:____**Date:**______________
Relationship to Patient:____

PARQ and discussion completed with patient:

____________________ ______________________________________

Date **Signature of Doctor**

Doctor Name: Michelle K. Jackson

Interpreter if applicable: